

October 05, 2020

The Honorable Seema Verma  
Administrator  
Centers for Medicare and Medicaid Services  
U.S. Department of Health and Human Services  
200 Independence Avenue SW  
Washington, DC 20201

Dear Administrator Verma,

On behalf of the undersigned specialties, we write to express our strong support for the visit complexity code (GPC1X) as proposed by CMS. We agree with CMS that the revised office visit evaluation and management (EM) codes still do not adequately describe or reflect the resources associated with primary care and certain types of specialty visits. We support CMS' decision to establish the GPC1X add-on code to account for these resources. At the same time and in response to the solicitation for feedback in the 2021 Medicare Physician Fee Schedule proposed rule, the American College of Physicians' Subspecialty Advisory Group on Socioeconomic Affairs (SAGSA) convened a workgroup representative of the specialties CMS indicated that would be most likely to bill GPC1X in order to respond to this CMS request. Over the course of 4 workgroup meetings, the workgroup collectively examined the GPC1X code descriptor and its utilization assumptions.

Ultimately, the workgroup recommended to SAGSA that the current GPC1X code descriptor fit its intended purpose and is well defined. After a review of the workgroup's recommendation, the undersigned specialty societies recommend that CMS should:

- Remove the comma between "single" and "serious" so that the GPC1X code descriptor reads: *"Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single serious, or complex condition."*
- Revise the estimated utilization assumptions to no more than **23% of estimated claims**;
- Ensure the add-on code is available to both ***new and established patients***; and
- Ensure the appropriate resource costs are accounted for in the code valuation.

The undersigned specialties believe that the Agency's proposal reflects the inherent accelerated resource costs in furnishing certain types of care by finalizing a new code (GPC1X) for visit complexity. This new code is warranted and will ensure that physicians have the necessary resources to care for their patients.

Additionally, SAGSA members encourage CMS to revisit the Agency's utilization assumptions for this add-on code. Currently, CMS projects that GPC1X will be applied to 75% of all office visit claims, an increase from the 50% projection in the 2020 rule. While CMS does not offer an explanation for this increased projection, the Agency's projection translates to about 187 million claims for GPC1X as found in utilization tables on the CMS website. However, it appears that if the intent is to append this add-on code to office visits related to ongoing care, CMS could examine past utilization history for Transitional

Care Management (TCM) codes (99495 & 99496) and Chronic Care Management (CCM) codes (99387, 99489 and 99490). Both of these code sets serve as a helpful barometer for measuring the provision of “ongoing care.” CMS previously estimated that there would be approximately 5.6 million claims for TCM. In fact, the actual utilization for TCM came in just under 300,000 the first year. Utilization for TCM was still less than one million after 3 years of implementation. 99495 and 99496 were respectively 22% and 20% of the 2019 claims volume when they became effective in 2013, with 99490 being 23% of the 2019 volume in its first year in 2015. Taken together, the combined 2019 utilization for 99495, 99496, 99387, 99489, and 99490 is just over 6 million claims. This is a very small fraction of the 187 million estimate from CMS. We agree with the RUC that 75% is a vast overestimate.

We also note that while the code will be widely applicable, GPC1X utilization could be as low as 5% of initial TCM utilization in 2013 primarily because adoption will be slow at first given the necessity for medical societies to educate their members about appropriate use. Additionally, widespread uptake of GPC1X will be counterbalanced by the ongoing implementation of the revisions to the office visit code set. Not to mention, CMS has provided advance notice about an anticipated delayed issuance of the fee schedule final rule which will delay education and communication efforts, as well as electronic health records (EHRs) integration. Finally, the persistence of the COVID pandemic and the implementation of a national vaccination strategy will also slow down the adoption of this add-on code. We strongly encourage CMS to take this information into account when considering an appropriate utilization estimate. **The undersigned societies agree that no more than 23% of estimated claims would be the appropriate utilization estimate for the GPC1X add-on code.**

Additionally, the undersigned specialties also agree that the code should be available for **both new and established patients**. Finally, we encourage CMS to ensure that the following resources are accounted for in the valuation of GPC1X:

- Actions at assisted living/nursing homes that require a physician response;
- Time spent by care/referral/medical record coordinators that help manage the ongoing flow of information;
- Physician time that is unique to ongoing management and thus inadequately addressed in the revised E/M. This includes oversight of medication refills, evaluating appropriateness of current and new medications, including those initially prescribed by other providers (e.g., ER, specialists, hospitalists) and conduct medication-related monitoring and safety activities when these activities are not part of a visit;
- Forms and review of consultant reports lab and imaging reports that fall outside the 3 days prior and 7 days after the timeframe of an E/M visit, but do not necessitate a new visit;
- Assume responsibility for relevant electronic medical record systems to track preventive services; reminders to patients, scheduling, monitoring, tracking results of these services;
- Assume responsibility for chronic disease management tracking – individual patient and populations; and
- Physician and/or staff responsibility for time spent coordinating care.

We greatly appreciate the opportunity to comment on this important code, as well as the Agency’s work to ensure that physicians and their teams have the resources they need to focus on caring for their patients. We look forward to working with CMS to ensure that this code is implemented appropriately.

Sincerely,

American Academy of Hospice and Palliative Medicine

American Academy of Neurology

American Association for the Study of Liver Diseases

American College of Allergy, Asthma and Immunology

American College of Physicians

American College of Rheumatology

American Geriatrics Society

Infectious Diseases Society of America

Society of General Internal Medicine